**UNITED STATES OF AMERICA**
**BEFORE THE NATIONAL LABOR RELATIONS BOARD**
**SEVENTH REGION**

**DETROIT MEDICAL CENTER,**
**REHABILITATION INSTITUTE OF MICHIGAN**[1]

**Employer**

**and** **CASE 7-RC-22286**

**LOCAL 79, SERVICE EMPLOYEES**
**INTERNATIONAL UNION, AFL-CIO**[2]

**Petitioner**

**APPEARANCES:**

**Stuart J. Katz,** Attorney, of Detroit, Michigan, for the Employer.
**Herbert A. Sanders,** Attorney, of Detroit, Michigan, for the Petitioner.

## DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, hereinafter referred to as the Act, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to the provisions of Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record[3] in this proceeding, the undersigned finds:

[1] The name of the Employer appears as amended at the hearing.
[2] The name of the Petitioner appears as amended at the hearing.
[3] The Employer and Petitioner filed briefs, which were carefully considered.

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.

2. The Employer is engaged in commerce within the meaning of the Act and it will effectuate the purposes of the Act to assert jurisdiction herein.

3. The labor organization involved claims to represent certain employees of the Employer.

4. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Sections 2(6) and (7) of the Act.

The Petitioner seeks to represent a unit of approximately 60 full-time, regular part-time, contingent, and float registered nurses (RNs) employed by the Employer at its adult rehabilitation hospital facility located in Detroit, Michigan. The Employer contends that the petitioned-for unit is inappropriate inasmuch as the RNs are supervisors within the meaning of Section 2(11) of the Act. The Employer additionally asserts that assuming, arguendo, the RNs are not supervisors, the unit as petitioned for must include six RNs employed as referral coordinators (RCs) and four RNs employed as quality improvement specialists (QISs). The Petitioner responds that these employees are properly excluded from the proposed unit as managerial employees and, moreover, they do not share a sufficient community of interest with the petitioned-for employees to be included in the unit.

I find that the Employer has satisfied its burden of proof that the regular full-time and part-time RNs are supervisors based primarily on their authority to act as charge nurses and develop nursing care plans. However, I find that the contingent and float RNs, who do not regularly act as charge nurses or participate in the development of nursing care plans, are non-supervisory and therefore eligible to vote, subject to certain voter eligibility requirements for the contingent RNs as described below. Finally, I find that the RNs employed as RCs and QISs must be included in the petitioned-for unit as non-managerial RNs pursuant to the Board's Health Care Rules. There is no history of collective bargaining at the facility with respect to RNs.

The Employer, Detroit Medical Center (DMC), a Michigan non-profit corporation, is engaged in providing acute care medical services in southeastern Michigan. The Rehabilitation Institute of Michigan (RIM), part of the DMC, provides rehabilitation medical services for spinal cord, orthopedic, stroke,

geriatric, and traumatic brain injury patients. RIM operates a nine-floor rehabilitation hospital in Detroit.

RIM is a 94-bed acute care facility. It currently has about 70 patients. There are three patient floors in the nine-floor facility. The fourth floor consists primarily of spinal cord and orthopedic patients[4]; the sixth floor consists of stroke and geriatric patients; and the seventh floor consists of traumatic brain injury patients. There is a nursing team assigned to each floor to care for patients, consisting primarily of RNs, licensed practical nurses (LPNs), and patient care associates (PCAs)[5]. Except for the float and contingent nurses, the nursing teams are assigned exclusively to one floor and do not rotate among floors.

RIM operates round-the-clock with day, afternoon and midnight shifts[6]. Scheduling of all nursing employees is handled by the NMs in conjunction with the administrative supervisors. The number of nurses per shift is based on patient census and the acuity of patients. "Acuity" is the functioning level of a particular patient, i.e., how much care and attention the patient needs. During the day shift, there are typically about 4 to 5 RNs, 1 to 2 LPNs, and 4 to 5 PCAs assigned per floor to 3 to 12 patients. During the afternoon shift, there are typically 4 to 5 RNs, 2 LPNs, and 4 to 5 PCAs assigned per floor to 3 to 12 patients. During the midnight shift, there are typically 2 to 4 RNs, 1 LPN, and 2 to 4 PCAs assigned per floor to 8 to 17 patients. During weekends and holidays, the nursing staff is generally decreased by one to two RNs, LPNs and PCAs.

The record indicates that LPNs at RIM have been represented for many years and have been subject to a series of collective bargaining agreements between the Employer and Petitioner. The Petitioner was recently certified to represent the PCAs at RIM for purposes of collective bargaining and negotiations for an initial contract are presently ongoing between the parties. There are approximately 7 LPNs and 60 PCAs presently employed.

All newly-hired DMC employees attend a three-day, system-wide orientation program. In addition, the RIM RNs, LPNs, and PCAs attend a two-

[4] There is some overflow of other patients to the fourth floor, as necessary, based on patient census.

[5] Unit clerks are also part of the nursing team, as described below. The nursing team works in conjunction with physical, occupational, and speech therapists.

[6] The day shift hours are 7:00 a.m. to 3:30 p.m.; the afternoon shift hours are 3:00 p.m. to 11:30 p.m.; and the midnight shift hours are 11:00 p.m. to 7:30 a.m. Some of the nursing staff employees also work 12-hour shifts from 7:00 a.m. to 7:00 p.m. or 7:00 p.m. to 7:00 a.m.

day orientation program at RIM, lead by an RIM nurse educator[7]. The RNs, LPNs, and PCAs are paid hourly and receive the same vacation, sick, and holiday benefits. The float pool RNs receive pro-rated benefits based on hours worked, and the contingent RNs apparently do not receive any benefits.

The day shift RNs report directly to a nursing manager (NM). There is one NM present on each patient floor during the day shift[8]. The NM desk is located in close proximity to the nursing station on each floor. The fifth floor at RIM contains administrative nursing offices, including the offices of the administrative supervisors, to whom the RNs on the "off-shifts", i.e., afternoon, midnight, weekend and holiday shifts, report directly[9]. The NMs and administrative supervisors report to the director of nursing (DON), Janice Simmons, who reports to the chief nursing officer, senior vice president for patient care, Iris Taylor[10].

Nursing schedules are posted four weeks at a time by the NMs and administrative supervisors. All RNs rotate as charge nurses and are paid a stipend of about two dollars. Float and contingent nurses do not act as charge nurses. The RNs decide amongst themselves who will serve as a charge nurse by signing up as a charge nurse on a regular rotating basis[11]. There is one charge nurse per floor, per shift, who acts as the lead RN on the floor during that shift. The charge nurse is responsible for making the initial assignments of RNs, LPNs, and PCAs to particular patients[12]; assigning breaks to all nursing employees; and assigning

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[7] The parties stipulated that Katrina Jones, the RIM nurse educator, is a managerial employee within the meaning of the Act and properly excluded from the petitioned-for unit. Jones reports to Jan Simmons, director of nursing, and Geraldine Jackson, director of education.

[8] The record indicates that the NMs often overlap into the midnight and afternoon shifts, sometimes arriving at work as early as 6:30 a.m. and leaving as late as 9:00 p.m. NM Nora Chimner is currently assigned to the fourth floor; NM Pamela Sherry is currently assigned to the sixth floor; and NM Frances Davis is currently assigned to the seventh floor. The record also indicates that there is a fourth NM who is in charge of the float pool nursing staff, which consists of about 4 float RNs and 13 float PCAs. The parties stipulated, and I find, that the NMs are supervisors within the meaning of Section 2(11) of the Act based on their authority to hire or fire employees, or to effectively recommend such action.

[9] There are five administrative supervisors: Gerald Wiegand, Audrey Byrd, Jacqueline Martin-Agbourche, Angela Allen, and Cherry Larry. The parties stipulated, and I find, that the administrative supervisors are supervisors within the meaning of the Act based on their authority to discipline employees, or effectively recommend discipline.

[10] Although the parties did not stipulate, based on the record I find that Simmons and Taylor are supervisors and/or managers within the meaning of the Act based on their authority to discipline employees.

[11] This process is monitored by the NMs and administrative supervisors.

[12] The RNs, LPNs and PCAs are generally assigned to the same floor and patients for continuity purposes.

routine tasks to LPNs and PCAs, such as checking crash carts and restocking medical supplies. In making patient assignments, the charge nurse considers patient and staffing census, patient condition, patient personality versus staff personalities, and continuity of care. When there is a staffing issue, such as not enough or too many nursing employees for a particular shift, the charge nurse reports to the NM or administrative supervisor, who then decides whether to call in extra employees, solicit previous-shift employees to stay for overtime work, solicit volunteers for taking a day off, or send employees home and require them to take a mandatory day off[13]. Although the charge nurse may attempt to resolve disputes among nursing employees, any unresolved disputes are brought to the NM or administrative supervisor. The charge nurse is also responsible for carrying a patient load and perform general RN nursing duties during the shift.

The RNs are responsible for overall patient care and work with the LPNs and PCAs to that end. The RN job description states that an essential function of the position is "[supervision of] the delivery of care by other team members." All RNs have graduated from professional schools of nursing and are licensed by the State of Michigan[14]. When a patient is admitted, the RN conducts a patient assessment and prioritizes the needs and problems of the patient. For example, an RN will examine a patient's skin and fluid intakes, take his or her vital signs, and do a neurological assessment of the patient.

A direct care plan is specifically designed by the RN to address the unique requirements of the patient and is maintained in the patient's medical record. To this end, the RN job description specifically states that "the RN assesses and monitors patient status by observing the patient, noting data collected by other team members, and analyzing this information to develop a plan of nursing care which is implemented by the care delivery team." Other caregivers (both LPNs and PCAs) use the care plan in treating the patient, and document their patient treatment by making notes in the patient's wall chart (also known as the "trending chart") located near the bedside[15]. Facility managers, including NMs and administrative supervisors, review neither the patient assessments nor the direct care plans. The RN regularly adjusts and updates the care plan, documents the patient chart with progress notes as the patient's needs and condition changes.

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[13] There is some indication in the record that a charge nurse may, when necessary, authorize overtime for nursing employees and/or call nursing employees in to work in the event of a staffing shortage. Such activity must be thereafter related to and ultimately approved by an NM or administrative supervisor.

[14] The parties stipulated to the professional status of the RNs.

[15] The RNs are authorized to make notations directly in patient charts which are also located near the bedside.

During the course of the shift, the RNs can make adjustments in the initial charge nurse assignment of tasks to the LPNs and PCAs, depending upon the RN's evaluations of patient conditions, treatments, and needs. In this regard, the RN will take into account the skills, abilities, and experience of their assigned LPNs and PCAs in deciding which LPNs and PCAs are best able to provide care for the patients. The RNs have authority among themselves to transfer LPNs and PCAs to different patients on the floor, but not to different floors. Only NMs, administrative supervisors, and staffing coordinators possess the authority to transfer nursing staff to different floors within the facility.

RNs have some authority to direct unit clerks (UCs), who are considered part of the nursing team, as well as patient support associates (PSAs), who are considered part of the Employer's environmental services department and support services team[16]. In this regard, the RNs may request UCs to perform certain duties such as paging a physician, inputting lab draws into the computer, and arranging for patient transportation. The RNs may also request the PSAs to perform certain tasks such as cleaning a patient room or obtaining a food tray for a patient. The PSAs are under the direct supervision of Donna Brown, PSA supervisor, who reports to Mark Bell-Bryan, director of support services.

The RNs regularly inspect the work of LPNs and PCAs and possess authority to discuss with them, or even document in writing, any deficient work performance. This written documentation concerning deficient work performance is in the form of anecdotal notes and may be considered by the NM or administrative supervisor when issuing discipline. However, the NM or administrative supervisor independently investigates any misconduct and makes the final decision regarding any discipline.

Nursing employees are formally evaluated by an NM at the completion of their probationary period and annually thereafter[17]. The RNs do not prepare or sign off on performance evaluations of LPNs or PCAs. The NM evaluations of LPNs and PCAs are based, in part, on the observations and ratings of the RN, who has worked closely with the LPN or PCA. However, the RN does not discuss job performance with the LPNs or PCAs, and does not participate in any evaluation discussion between the NM and the LPN or PCA. These evaluations can affect only the pay rates of non-union employees and a negative evaluation can result in

[16] The UCs and PSAs have been union-represented for many years and are currently covered by a joint operating agreement in effect between the Employer, Petitioner, and American Federation of State, County and Municipal Employees (AFSCME) Council 25, Locals 181, 3695 and 140. The parties stipulated that both UCs and PSAs are properly excluded from the petitioned-for unit.

[17] The probationary period extends from 90 to 120 days.

the implementation of a work improvement plan. The evaluation goes into the personnel file of the LPN or PCA, to which the RN does not have any access.

Some RNs work as "preceptors" and are responsible for mentoring probationary employees, including RNs, LPNs, and PCAs[18]. The preceptor RN monitors and inspects the work of the new nursing employee and completes an evaluation-type checklist at the end of the probationary period confirming the nursing employee's understanding and appropriate completion of assigned job duties. The preceptor RN can recommend that the new employee either pass or fail the probationary period. However, the NM or administrative supervisor ultimately evaluates the probationary period and determines whether the new employee will be retained as a permanent employee. The preceptor RN receives premium pay.

RNs do not participate in the hiring interviews of any LPNs or PCAs. Rather, such interviews are conducted by the NMs. They do participate to some extent, along with an NM, in the group hiring interviews of NMs, clinical nurse specialists, nurse practitioners, and therapist supervisors[19]. But there is no evidence they make effective recommendations to hire any of these individuals. The NM has the final authority regarding all such hiring decisions. RNs do not have the authority to hire, fire, discipline, promote, or transfer employees. However, RNs may send employees home for blatant insubordination. RNs cannot grant wage increases to the nursing staff.

There is a float pool consisting of approximately 17 supplemental staff employees (4 RNs and 13 PCAs), who are assigned to a floor by either Mary Ann Joly, staffing coordinator, an NM, or an administrative supervisor, based on patient census and staffing needs. The float pool RNs are not assigned to any floor on a regular basis, however, they all work as either full-time or regular part-time employees. Float RNs do not serve as charge nurses. There are three contingent RNs presently employed by RIM. They do not regularly serve as charge nurses. The record is unclear as to the average number of hours worked by these contingent RNs.

[18] The record indicates that generally the more senior RNs work as preceptors.

[19] The parties stipulated that clinical nurse specialists and nurse practitioners are managerial employees within the meaning of the Act and properly excluded from the petitioned-for unit.

There are four QISs who report directly to Elizabeth Wall, director of quality improvement and accreditation. They are salaried RNs[20] on RIM's payroll. One QIS works on the fifth floor and three QISs work on the eighth floor. They are not involved in direct patient care. Rather, they view accreditation standards and quality of insurance issues, as well as examine quality-related issues at RIM, such as utilization, length of patient stay, criteria for medication administration, and restraint usage, to ensure compliance with hospital standards. The QISs have some contact with staff RNs, including reviewing patient medical records on the patient floors about every three to five days, and speaking with RNs regarding patient care issues if necessary. QISs do not oversee any other employees.

Six salaried RCs report directly to Eileen Wilhelm, RC supervisor. They work at other hospital facilities[21], off-site from RIM, and are responsible for reviewing admission criteria policy and evaluating potential RIM patients regarding insurance issues. The RCs have minimal interaction with RNs, in the petitioned-for unit limited to advising an RN by telephone regarding an incoming patient's special needs. The RCs are not engaged in any direct patient care. RCs do not oversee any other employees.

Section 2(3) of the Act excludes from the definition of the term "employee" "any individual employed as a supervisor." Section 2(11) of the Act defines a "supervisor" as:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not merely of a routine or clerical nature, but requires the use of independent judgment.

Section 2(11) is interpreted in the disjunctive and the possession of any one of the authorities listed in that section places the employee invested with this authority in the supervisory class. ***Ohio Power Company. v. NLRB***, 176 F.2d 385 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949); ***Allen Services Co.***, 314 NLRB 1060 (1994).

[20] Salaried employees' benefits differ from the benefits of hourly employees as to sick time and vacation accrual benefits.

[21] About 90 percent of these facilities are DMC-owned and operated.

In ***NLRB v. Kentucky River Community Care***, 521 U.S. 706 (2001), the Supreme Court upheld the Board's longstanding rule that the burden of proving Section 2(11) supervisory status rests with the party asserting it. See ***Ohio Masonic Home***, 295 NLRB 390, 393 fn. 7 (1989); ***Bowen of Houston, Inc.***, 208 NLRB 1222, 1223 (1986). However, the court rejected the Board's interpretation of "independent judgment" in Section 2(11)'s test for supervisory status, i.e., that registered nurses will not be deemed to have used "independent judgment" when they exercise "ordinary professional or technical judgment in directing less-skilled employees to deliver services in accordance with employer-specified standards." 121 S.Ct. at 1863. Although the Court found the Board's interpretation of "independent judgment" in this respect to be inconsistent with the Act, it recognized that it is within the Board's discretion to determine, within reason, what scope or degree of "independent judgment" meets the statutory threshold. See ***Beverly Health & Rehabilitation Services***, 335 NLRB No. 54 (Aug. 27, 2001). However, the Court did agree with the Board in that the term "independent judgment" is ambiguous as to the *degree* of discretion required for supervisory status and that such degree of judgment "that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and regulations issued by the employer." 121 S.Ct. at 1867. In discussing the tension in the Act between the Section 2(11) definition of supervisors and the Section 2(12) definition of professionals, the Court also left open the question of the interpretation of the Section 2(11) supervisory function of "responsible direction," noting the possibility of "distinguishing employees whom direct the manner of others' performance of discrete tasks from employees who direct other employees." 121 S.Ct. at 1871. See ***Majestic Star Casino***, 335 NLRB No. 36 (Aug. 27, 2001).

For instance, direction as to a specific and discrete task falls below the supervisory threshold if the use of independent judgment and discretion is circumscribed by the superior's standing orders and the employer's operating regulations, which require the individuals to contact a superior when anything unusual occurs or when problems occur. ***Dynamic Science, Inc.***, 334 NLRB No. 56 (June 27, 2001); ***Chevron Shipping Co.***, 317 NLRB 379, 381 (1995).

In the instant case, that RNs devise direct care plans of action tailored to specific patients based on their own assessments of the patients. These assessments are not subject to review by other management officials and they provide precise, detailed instructions to LPNs and PCAs as to the care and treatment of patients. See ***Beverly Health & Rehabilitation Services***, supra, slip op. at pg. 36, wherein charge nurses who were admitted supervisors, provided similar detailed instructions to LPNs. Even assuming that RNs defer their exercise of authority to assign particular work to specific caregivers, and instead on

occasion allow the caregivers themselves to decide which patients or tasks to perform, their directives as to each patient are nevertheless predetermined by the RN's independent assessment of the patient's needs and requirements. In addition, RNs inspect and approve PCA wall chart/trending chart notes, which are used to ensure that patient care tasks are completed by the caregivers. That RNs must administer medication according to a physician's standing orders and are guided in treating certain patient conditions by protocols does not detract from the independent judgment the RNs exercise in translating those orders and policy into specific plans of care. Based on this indicia of supervisory authority alone, I must conclude that the RNs are supervisors within the meaning of Section 2(11) of the Act.

I do not find that the RNs' role in the disciplinary and evaluation process support a finding of supervisory status.

The RN's responsibility in the area of discipline is to serve as a conduit to management by reporting misbehavior and preparing anecdotal notes. Higher management independently investigates and determines disciplinary action, if any. The Board does not find anecdotal reports or written warnings to be proof of supervisory authority unless they result in personnel action without independent investigation or review by others. ***Hillhaven Rehabilitation Center***, 325 NLRB 202, 203 (1997); citing ***Northcrest Nursing Home***, 313 NLRB 491, 498 (1993). The Board has repeatedly held, with court approval, that a reportorial function is not sufficient to support a supervisory finding. ***Ohio Masonic Home***, supra at 393-394; ***NLRB v. Attleboro Associates, Ltd.***, 176 F.3d 154, 174 (3rd Cir. 1999); NLRB v. ***Grancare, Inc.***, 170 F.3d 662, 668 (7th Cir. 1999); ***NRLB v. City Yellow Cab Co.***, 344 F.2d 575, 580-581 (6th Cir. 1965).

With regard to employee evaluations, the Employer argues that the preceptor RN probationary evaluations, exclusively relied upon by the NM in completing the formal evaluation of the probationary employee, are instrumental in determining whether to retain the probationary employee for permanent employment. Additionally, the Employer argues that the input received from RNs regarding their observations and rankings of LPNs and PCAs, is heavily relied upon by the NM in completing the formal annual evaluations of LPNs and PCAs, and is instrumental in determining whether those employees will receive a wage increase for successful performance, or possibly be placed on a work improvement plan for deficient performance.

However, the record does not demonstrate that either the preceptor RNs or other RNs discuss job performance with the LPNs or PCAs related to their probationary or annual evaluations, or participate in any evaluation discussion

between the evaluating NM and the LPN or PCA. At the most, RNs merely submit their observations to the NM as to the competence of the employee, without any recommendation regarding job tenure, pay increases, or job status. The NM completes the formal evaluations of all nursing employees and may or may not incorporate the input received from the RN into the NM comment section on the evaluation form. The evaluations forms are signed by the NM, DON, and evaluated employee only. Thus, it appears that the NMs retain the authority to determine and effectuate any personnel actions flowing from the evaluations. The Board has consistently declined to find supervisory status when RNs perform evaluations that do not, by themselves, affect other employees' job status. ***Washington Nursing Home***, supra at 371; ***Hillhaven Rehabilitation Center***, supra at 203, citing ***Ten Broeck Commons***, 320 NLRB 806, 813 (1996); ***Custom Mattress Mfg***., 327 NLRB 111 (1998); ***Lynwood Health Care Center, Minnesota, Inc. v. NLRB***, 148 F.3d 1042 (8th Cir. 1998); ***New York Univerisity Medical Center v. NLRB***, 156 F.3d 405, 413 (2nd Cir. 1998). Thus, I conclude that the RNs' participation in the evaluation process of other RNs, LPNs, and PCAs do not manifest supervisory authority under Section 2(11) of the Act.

Likewise, the participation of RNs in group hiring interviews of supervisors or management employees is insufficient to establish supervisory status. First and foremost, none of these individuals qualify as "employees" under Section 2(11). But aside from that, they do not make effective hiring recommendations.

There is no evidence that the RNs, as charge nurses or otherwise, are empowered to adjust any formal employee grievances. The limited authority exercised by RNs to resolve interpersonal conflicts among employees does not confer supervisory status. ***St. Francis Medical Center-West***, 323 NLRB 1046, 1047-1048 (1997).

However, further supporting this finding of supervisory status are certain secondary indicia, such as RNs covering for staff shortages by requiring employees to stay past their scheduled work times. Also, RNs may send employees home for blatant insubordination, and for at least some substantial periods during the off-shifts, are the highest ranking employees on the facility premises. ***Mid-America Care Foundation v. NLRB***, 148 F.3d 638 (6th Cir. 1998).

Accordingly, I find the RNs employed at the Employer's RIM facility to be Section 2(11) supervisors.

Regarding the float and contingent RNs, as it appears that they do not regularly serve as charge nurses or participate in the development of patient care plans because they frequently work on different floors without any consistency in

their patient care assignments and duties, I conclude they are non-supervisory RNs. I find that the float RNs are eligible to vote as full-time or regular part-time non-supervisory employees.

With regard to the contingent RNs, the record is devoid of evidence regarding the number of hours they work or the regularity of their work schedules. For on-call employees who work on a regular basis, the Board utilizes the eligibility formula set forth in ***Davison-Paxon Co.,*** 185 NLRB 21 (1970), and ***Sisters of Mercy Health Corp.,*** 298 NLRB 483 (1990). Accordingly, contingent RNs are eligible to vote in the election ordered here is if they regularly average four hours or more of work per week during the quarter immediately prior to the eligibility date. As I am unable to determine the status of the contingent RNs based on the present record, they shall be permitted to vote under challenge if they are otherwise eligible.[22]

Regarding whether the RCs and QISs should be included in the petitioned-for unit, the Petitioner argues that such employees are managerial employees and therefore excludable from the petitioned-for unit. The Board has long held that managerial employees are those who formulate and effectuate management policies by expressing and making operative the decision of their employer and who have discretion in the performance of their jobs independent of their employer's established policies. ***S.S. Joachim and Anne Residence***, 314 NLRB 1191, 1194 fn. 6. The instant record shows that the RCs and QISs participate in decisions regarding patient length of stay, and quality of patient care and treatment. Their decision-making does not involve the formulation of management policy and they do not have the discretion to deviate from the Employer's established policies. Thus, I do not find that the RCs and QISs are managerial employees within the meaning of the Act.

In the alternative, the Petitioner argues that the RCs and QISs possess an insufficient community of interest to be includable with the non-supervisory RNs in the petitioned-for unit because they do not engage in direct patient care and have limited contact with other unit RNs. However, RCs and QISs are licensed RNs and fall within one of the eight established appropriate bargaining units applicable to acute care hospitals as provided by the Board's Health Care Rules. The RN unit promulgated by the Rules is not limited to RNs engaged only in direct patient care 284 NLRB 1543-1552. Thus, I conclude that RCs and QISs must be included in the petitioned-for unit of non-supervisory RNs.

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[22] Furthermore, I reserve for future resolution, if necessary, whether it is more appropriate to utilize the eligibility formula of ***Marquette General Hospital,*** 218 NLRB 713 (1975), if there exists a significant difference in the number of hours worked by contingent RNs.

5. For the above reasons, and based on the record as a whole, the following employees of the Employer constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act[23]:

> All float RNs, contingent RNs and full-time and regular part-time referral coordinators and quality improvement specialists employed by the Employer at its Rehabilitation Institute of Michigan facility located at 261 Mack Avenue, Detroit Michigan; but excluding all nurse managers, licensed practical nurses, patient care associates, physical therapists, occupational therapists, speech therapists, technical employees, clerks, office clerical employees, guards and supervisors as defined in the Act.

[23] The Petitioner indicated it will participate in an election in any unit found appropriate. As the unit found appropriate is larger than the unit requested, the Petitioner is accorded a period of 14 days from the date of this Decision and Direction of Election in which to submit to the Regional Director for Region 7, an additional showing of interest, if necessary. In order to facilitate a check of the showing of interest, the Employer is requested to immediately submit an alphabetized list of employees included in the unit. In the event the Petitioner does not wish to proceed with an election, it may withdraw its petition without prejudice by notice to the Regional Director for Region 7, within 14 days from the date of this Decision and Direction of Election.

Those eligible shall vote as set forth in the attached Direction of Election.

Dated at Detroit, Michigan this 9th day of September 2002.

/s/ William C. Schaub, Jr.

(SEAL)

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